GENERAL LIBRARY
SEP 9 1919
UNIV. OF VA.

[ROANOKE NUMBER]

Virginia Medical Monthly

Established April 1874 — By LANDON B. EDWARDS, M. D.

OFFICIAL ORGAN OF THE MEDICAL SOCIETY OF VIRGINIA

Fiftieth Annual Session, Richmond, October, 1919

VOL. 46, NO 6
WHOLE NO 8 7

RICHMOND, VA., SEPTEMBER, 1919

$2.00 A YEAR
20 CENTS A COPY

[Entered at Post-Office at Richmond, Va., as second-class matter.]

CONTENTS.

ORIGINAL COMMUNICATION:
Flat Feet. By W. L. Powell, M. D., Roanoke, Va. 131

Treatment of Chronic Pyelitis. By S. Beverly Cary, M. D., Roanoke, Va. 133

Radical Mastoid Operation—Indications. By Elbyrne G. Gill, M. D., Roanoke, Va. 134

A True and Tried Trio. By Robert H. Garthright, M. D., Vinton, Va. 137

The Why and the How of Electronic (Radiant) Force—Physical Diagnosis—Correlation with Gross and Medium Methods—Some Remarks on Syphilis—Thesis No. 5. By H. E. Jones, M. D., Roanoke, Va. 139

A Report of Two Cases of Personal Interest—A Word in Defense of the Tonsils, and Particularly as Related to Singing-Voice Production. By M. R. Faville, M. D., Roanoke, Va. 142

Some Guy Ropes for the Doctor in Practice. By J. D. Willis, M. D., Roanoke, Va. 144

Treatment of Burns. By Fauntleroy Flinn, M. D., Roanoke, Va. 145

PROCEEDINGS OF SOCIETY, ETC. 147

THE COUNTY SOCIETY 150

EDITORIAL 152

OBITUARY RECORD 158

FOR MEDICAL SOCIETY ANNOUNCEMENTS SEE PAGE 8.

INDEX OF ADVERTISERS—Advertising Page 5.

BLAKISTON

TWO PRACTICAL BOOKS
For Everyday Use

HUGHES
PRACTICE OF MEDICINE

11th Edition. 63 Illustrations. 12mo; XIX+785 pp. Full Limp Leather, Gilt Edges, Round Corners, $4.00. Cloth, $3.25, postpaid.

Giving the Synonyms, Definitions, Causes, Symptoms, Pathology, Diagnosis, Prognosis, Treatment, etc., of each Disease. By DANIEL E. HUGHES, M. D.

Thoroughly Revised by R. J. E. SCOTT, M. A., B. C. L., M. D. *Fellow of the New York Academy of Medicine.*

SLUSS
EMERGENCY SURGERY

4th Edition, Revised and Enlarged. 685 Illustrations, some of which are Colored, 847 pp. Full Limp Leather, Gilt Edges, Round Corners. $4.75; Cloth, $4.00, Postpaid.

By JOHN W. SLUSS, M. D., *Associate Professor of Surgery, Indiana University School of Medicine, Indianapolis; Surgeon to the Indianapolis City Hospital, etc.*

P. BLAKISTON'S SON & CO.
PUBLISHERS——1012 WALNUT ST.——PHILADELPHIA

SPECTACLES
EYEGLASSES
Artificial Eyes

KODAKS
SUPPLIES
FINISHING

The S. Galeski Optical Co.

LEADING—LARGEST—OLDEST
OPTICAL HOUSE SOUTH

RICHMOND
Main and 8th Streets
223 E. Broad St.

NORFOLK
209 Granby Street

ROANOKE
211 S. Jefferson Street

℞ WORK
OUR
SPECIALTY

OPHTHALMO
LOGICAL
SUPPLIES

The Management of an Infant's Diet

A Temporary Diet in Summer Diarrhea

Mellin's Food . . **4 level tablespoonfuls**
Water (boiled, then cooled) . **16 fluidounces**
To be given in small amounts at frequent intervals.

Each ounce of this mixture has a food value of 6.2 Calories and furnishes immediately available nutrition well suited to spare the body-protein, to prevent a rapid loss of weight, to resist the activity of putrefactive bacteria, and to favor a retention of fluids and salts in the body tissues.

MELLIN'S FOOD COMPANY, BOSTON, MASS.

Virginia Medical Monthly

Official Organ of the Medical Society of Virginia

VOL. 46, NO. 6.
WHOLE NO. 807.

RICHMOND, VA., SEPTEMBER, 1919.

$2.00 A YEAR
20 CENTS A COPY

Original Communications.

FLAT FEET.

By W. L. POWELL, M. D., Roanoke, Va.

The term flat foot is a relative one so far as function is concerned. The foot should be judged by what it can do, rather than by the height of the longitudinal arch. An important phase of the work of orthopedic surgeons in the army was to determine the ability of the foot of an individual to bear strain. To do this with any degree of accuracy it is necessary to take into consideration not only the height of the longitudinal arch, but still more important, the muscular development of the foot, the ability of the individual to correct any apparent abnormality voluntarily, and to determine whether the range of dorso-flexion, plantar-flexion and inversion were normal. It is necessary to observe any areas of callosities beneath the heads of the metatarsal bones, to prescribe proper shoe correction and foot exercises for those potentially weak, and to distinguish between the malingerer and those who really were suffering from foot abnormalities. The result of this work has impressed the profession with the great number of weak and flat feet present in young men. This was one of the most frequent causes for rejection and classifications of men "For domestic service only." It seems wise to bring this matter to the attention of the general practitioner, that he may be on the lookout for these conditions that remedial measures may be applied early.

In considering the pathological conditions of the foot it must be regarded as an active organ of locomotion rather than a passive support, and a knowledge of its various ligamentous, bony and muscular structures is necessary in order to interpret the pathological.

The foot is composed of tarsal, metatarsal and phalangeal bones held together by interosseous and capsular ligaments. The motion between any two bones is very limited, but considered in the aggregate it is a decidedly mobile organ. The longitudinal arch extends along the inner side of the foot from the head of the first metatarsal bone to the internal tuberosity of the os calcis, the highest point being at the neck of the astragalus. This arch is maintained by strong fibrous bands or ligaments which function as the strings of a bow, and on these falls the strain of maintaining the arch in its normal position when one is standing, but they are aided and supported to a marked degree by muscular structures when the foot is used in locomotion. The four ligaments most depended on to maintain the longitudinal arch in its normal position are the internal calcaneo scaphoid, the plantar, long and short, the deltoid, and the plantar fascia. The internal calcaneo-scaphoid extends from the sustentaculum tali to the scaphoid running beneath the head of the astragalus, but not attached to it. The plantar ligaments extend from the os calcis in front of the tuberosities to the base of the metatarsal bones and act as a longer string to the bow, the plantar fascia being the longest and most superficial of the strings. The deltoid, extending from the internal malleolus to the os calcis and tuberosity of the scaphoid acts as an upright support.

The long extrinsic muscles, having their origin on the anterior surface of the leg, are depended on to take the strain off the non-elastic ligaments. The tibialis anticus coming down the leg in front of the internal malleolus is attached to the internal cuneiform and the base of the first metatarsal: the tibialis posticus, descending behind the internal malleolus, is attached to the tuberosity scaphoid. These are the most important longitudinal support. Between the strings of the bow are the flexor, abductors and adductor muscles of the foot which, if properly developed, play an important part in maintaining the arch in its proper position.

The transverse arch extends from side to side from the midtarsal joint to the heads of the metatarsal bones, resting on the heads of

the first, fourth and fifth, forming the anterior extremity of the tripod on which the foot stands.

In civil practice we are not concerned to any extent with malingers. Patients come to us because they are suffering and want relief, and will usually give us their full co-operation as long as they are suffering, but unfortunately are apt to discontinue treatment as soon as relief is obtained and before cure is effected. The most frequent causes of foot disabilities are tight and improperly fitted shoes, poor muscular development, faulty foot positions, both standing and walking, infection, undue strain on poorly developed muscles, following illness, walking on hard surfaces, congenital or certain occupations demanding standing for long hours, such as waiters, cooks, etc.

The chief requisite in the proper shoe is that it should be broad enough in the fore part to allow the intrinsic muscles room for their proper action and this will lead to their proper development. The heel should be tight enough to prevent slipping, should be concave on its upper surface, and about one inch high, placed beneath the heel of the foot rather than slanting forward. A line extending from the inner side of the heel to the ball of the great toe should be straight. The shank should be moderately firm and convex upward. It is very difficult to get a woman to wear the proper shoe; in fact very few are made, and in the best of these some concessions are made to the prevalent idea of style. Poor muscular development is usually the result of tight shoes and sedentary life, the intrinsic muscles not having a chance to function properly.

A line dropped from the middle of the patella should fall along the line of the second metatarsal bone or between that and the first. When toeing out is practiced this line falls inside this point, and the maximum of strain falls on the high part of the longitudinal arch. If the practice is continued it is apt to be followed by a descent of the arch, the head of the astragalus slips downward and inward, the tuberosity of the scaphoid and internal malleolus becomes very prominent, and the foot is abducted both in front and behind this point. If there should be any foci of infection present at this time from which absorption is constantly taking place, there is a strong probability that there will be arthritic changes and we will have more or less permanent deformity, rigid, pronated flat foot. This condition gives rise to the shuffling gait in which the feet are used as props rather than flexible organs of locomotion. In this position the head of the femur is rotated forward, the anterior half of the pelvis is tilted upward, one of the frequent causes of backache.

It is not infrequent for foot disability to develop in persons who have had good serviceable feet before an acute illness. They are allowed out of bed too early, usually wearing slippers; the muscles are weakened by disuse and diseased processes, and, on attempting the normal activities before these have recovered, symptoms of foot strain develop, which, if not recognized and treated early eventually become a source of permanent discomfort. Infection of any kind, but especially gonorrhea, may produce arthritic changes with consequent pain, tenderness and permanent rigidity.

In infancy there is no longitudinal arch, but as the bony ligamentous and muscular structures gradually develop in a normal way one is formed. Unfortunately some cases fail of the normal development in this respect, and we have what is termed congenital flat foot. Nearly all the disabilities of the longitudinal arch may be benefited if not cured, but the longer the disability the more fixed the bones become in their abnormal position, the longer will be the period of recovery. This cannot be accomplished without the faithful cooperation of the patient and, to secure this to the fullest extent they should be seen frequently and impressed with the fact that if faulty foot position and lack of muscular development persists their disability will return regardless of any mechanical device which may be used. The army has converted many to the sensible shoe, yet it is to be regretted that many discard the lesson which they have learned with their uniform, and put on their improper shoes with their civilian clothes.

The best results in treating flat feet are obtained, as would be expected, in those who are seen early. It must be remembered that it is not necessary that the longitudinal arch be down, as the early stage of flat foot, that is, foot strain, is often seen in those who have a high arch. A diagnosis must be made on the subjective symptoms of a pain across the dorsum, the inner side of the foot, painful heel and in the calves of the legs. Objectively, there will be found points of tenderness over the

attachments of the astragalo-scaphoid and plantar ligaments. The ligaments themselves have no sensory supply, but pain is experienced at their periosteal attachments.

Occasionally this condition will require absolute rest in the early stages of its treatment, but can usually be corrected by proper shoes, the teaching of proper feet positions, exercises designed to develop both the intrinsic and extrinsic muscles, and a support of felt either strapped to the foot or placed permanently in the shoe beneath the inner sole. Metallic arch supports, if used at all, should be made to fit the individual foot, and then in exceptional conditions, should they be worn for a conisderable time. Unless they are properly selected and properly fitted in cases in which they are used they may do a great deal of harm by traumatizing the already injured structures. They may give temporary relief, but are not conducive to the proper development of the muscles which are depended on to ultimately cure the condition.

Physicians should discontinue the practice of sending patients, consulting them for foot trouble, to a shoe store to "get an arch support." Shoe clerks, as a rule, know nothing about the pathological condition of the feet and will sell the most expensive supports whether they are needed or not. It is due these patients that they should have the same careful examination and treatment as you would give them if they were suffering with some complaint which you considered "in your line."

In cases in which arthritic changes have taken place no effort should be made to correct the faulty position as long as the infection is active. Absolute rest and elimination of the foci of infection are the first requisites, and later, when the acute symptoms have entirely subsided and the foci have been removed, adhesions may be broken up and the foot put in an over-corrected position.

A congenital flat foot should be put in an over-corrected position as early as possible and maintained there while walking, until the bony ligamentous and muscular structures have developed sufficiently to maintain the foot in a normal position.

In the different stages of flat foot, between foot strain, rigid flat foot and congenital flat foot, there are found numerous conditions which have their different requirements so far as treatment is concerned. Flat foot in its different stages is one of the most disabling conditions with which we have to deal, and probably the most neglected by the general practitioner. If recognized early and proper treatment is given, no class of cases give better results.

TREATMENT OF CHRONIC PYELITIS.

By S. BEVERLY CARY, M. D., Roanoke, Va.

By pyelitis we mean an inflammation of the kidney pelvis without involvement of the parenchyma. Pyelonephritis is the term applied when the infection spreads to the substance of the kidney. Should suppuration take place we have a pus kidney, which is known as pyonephrosis. However, in this paper, I will deal only with the chronic simple form of pyelitis.

It might be well to discuss the disease briefly before taking up the treatment. Before the advent of the cystoscope and ureteral catheter, very little was understood in regard to the diagnosis and treatment of surgical conditions of the kidney. The diagnosis must necessarily have been inaccurate and the treatment conducted in a rather inadequate way.

Pyelitis may be unilateral or bilateral, the latter being more frequently found. The method of invasion may be hematogenous, lymphogenous, urogenous, or by direct extension. It is sometimes difficult to determine in a given case which route is the source of infection.

Among the predisposing causes which are most common in pyelitis are those producing mechanical pressure, such as a neoplasm or gravid uterus, acting by interfering with the local blood supply; or an obstruction which interferes with the outflow of urine, giving rise to retention and stagnation. The immediate etiological factor is bacterial, the colon bacillus being most frequently found. However, we must bear in mind that the mere finding of bacteria in the kidney pelvis does not mean pyelitis, because bacteriurias of pelvic origin are common without signs of inflammation. Next in frequency to the colon bacillus is the staphylococcus albus and aureus. Of the two the latter is the more common. The least frequent invaders are the streptococci, pneumococci, bacillus proteus vulgaris, bacillus typhosus, gonococcus, bacillus mucosus capsulatus, etc.

The diagnosis of pyelitis should be by exclusion. To insure the best results the predisposing factor must be determined and removed so far as possible before direct treatment is instituted. To make an accurate diagnosis the ureters must be catheterized and the specimens obtained studied by culture and by microscope. In many cases it is advisable to inject the kidney with thorium nitrate or sodium bromide and radiograph to determine whether there is tissue destruction, and, if so, the extent of it. The phthalein functional test is of the greatest value in determining whether there is serious parenchyma involvement. The differentiation of a simple pyelitis from pyelonephritis would be practically impossible without the aid of a functional estimation. In pyelonephritis the phthalein output is decreased in proportion to the amount of tissue destruction, and in simple pyelitis the output ranges within normal limits.

Cystitis of some degree is practically always associated with an infection of the upper urinary tract, the bladder symptoms varying according to the degree of infection and the acuteness. All cases of cystitis, especially those which respond slowly and of the recurrent type, should undergo a cystoscopic examination and, at the same time, catheterization of the ureters. It is a great loss of time and an inconvenience to the patient to continue a treatment for cystitis when there is an infection of the upper urinary tract which is continually descending in the urine. Experience with these cases has taught me to look upon a cystitis as only a part of an infection of the urinary tract until it has been demonstrated conclusively by careful examination that nothing else exists which could be responsible for the symptoms complained of.

After an accurate diagnosis is made and predisposing causes are removed so far as possible, treatment is instituted at the earliest moment. Renal lavage is the most important procedure at our disposal and is the one on which we base our results. Many lavage solutions have been recommended, but at the present time we find that silver nitrate in 1 per cent to 3 per cent solution gives the most gratifying results. We begin with a 1 per cent solution and inject 5 to 10 c.c. by the gravity method. The strength of the solution is increased at each sitting. These lavages are given at from five- to seven-day intervals, the total number varying according to the individual case. However, from three to five are usually sufficient. A rather severe reaction sometimes follows from injections of strong silver solutions, but it is attended with no harmful results. This reaction is probably due to a congestion of the ureter produced by chemical irritation. In the majority of instances the inconvenience complained of is referable to the bladder which is more sensitive to strong silver solution than the kidney pelvis, as the former has a more abundant nerve supply. However, the bladder irritation can in a large measure be prevented by injecting several ounces of saline into the bladder before withdrawal of the catheters. The saline protects the bladder by taking up the silver as it comes from the ureters.

In conjunction with the treatment outlined, autogenous vaccines are sometimes given. We begin with a very small dose and gradually increase until there is a well-marked local and general reaction. The dosage necessary for this reaction is the maximum amount that should be used at each succeeding injection. It is difficult to say whether or not vaccine therapy is of much value in this class of cases, as I have always used it with a more rational method of treatment and never alone.

Internal administration of drugs is carried out as a matter of routine, as well as the general line of treatment recommended in this type of disease.

During the past three years quite a large number of pyelitis cases have come under my observation. Nearly all of them were put on the treatment outlined. The results have been uniformly good, and in many cases the progress has been so rapid as to exceed all expectations. Before these patients are discharged, a careful microscopic and bacteriological examination must be made of the catheterized specimens, and at least two negative cultures should be obtained before we can be reasonably sure there will not be a return of symptoms at a future date.

Suite 315 MacBain Building.

RADICAL MASTOID OPERATION: INDICATIONS.

By ELBYRNE G. GILL, M. D., Roanoke, Va.

The organ of hearing consists of three portions: the external, middle, and internal ear. The external consists of the auricle and exter-

nal auditory meatus. The former is of little importance physiologically: the latter is the canal which leads inward to the tympanic membrane.

The middle ear is composed of the tympanum, the mastoid antrum, and the mastoid cells. The tympanum, an air chamber, communicates with the naso-pharynx by means of the Eustachian tube and contains a chain of movable bones—the malleus, incus and stapes. The mastoid antrum and mastoid cells are air chambers accessory to the tympanum.

The internal ear, the innermost, and, at the same time, the essential part of the organ of hearing, is situated in the substance of the petrous portion of the temporal bone and consists of two sets of structures. First, a series of cavities hollowed out of the bone and constituting the bony labyrinth: these cavities are continuous with each other and are named from below backward the cochlea, vestibule,and semi-circular canals. Second, a membranous labyrinth situated within, but not nearly filling the bony labyrinth. The bony labyrinth contains perilymph and the membranous labyrinth the endolymph and the auditory nerve.

We will briefly mention the difference between the simple mastoid and radical mastoid operations. In the simple mastoid we operate to *relieve* an acute condition of the middle ear and mastoid cells, while a radical mastoid operation signifies one which aims to relieve chronic middle ear suppuration. The simple operation consists essentially of removing the mastoid cortex, the underlying diseased cells, opening and thorough drainage of the mastoid antrum, and in nearly every instance in an adult, the removal of the mastoid tip. The radical mastoid operation consists in a conversion of the middle ear, antrum and any diseased spaces within the mastoid into a single cavity, which is primarily drained through the external auditory meatus and ultimately lined by integument continuous with that of the membranous canal.

Before going into the different steps of the radical operation we will say something of the etiology, symptoms and signs of chronic middle ear suppuration. This is a term applied to any tympanic inflammation giving rise to a perforation of the drum membrane which shows no tendency to heal and through which there is a more or less constant flow of pus.

Probably 20 per cent of all cases of chronic middle ear suppuration are traceable to the infectious diseases of childhood, such as scarlet fever, diphtheria, measles and whooping cough. Influenza also contributes its quota. Repeated attacks of acute otitis media almost invariably develop into chronic aural suppuration. *Adenoids* predispose the child so markedly to acute middle ear disease and interfere so effectively with spontaneous recovery that they must be included among the active causes of chronic purulent otitis media. This explains in some degree the greater frequency with which the disease develops in childhood as compared with adult life. Practically every case of chronic aural suppuration can be prevented if proper care and management are given to the first attack of acute purulent otitis media.

A suppurative process which by extension may reach the labyrinth, the brain cavity, or lateral sinus, is capable of producing a varied and complex phenomenon, but for the sake of brevity we will say, aside from the discharge and the physical signs viewed through the aural speculum, many patients endure these lesions for years without pronounced symptoms either local or systemic.

The two cardinal symptoms are the discharge and impairment of hearing. The discharge ranges anywhere from a slight, intermittent, muco-purulent, to one that is constant and profuse. The discharge is in some cases so indescribably offensive as to constitute in a degree a social barrier between the patient and his fellows.

To a certain extent the hearing is impaired in almost every case of chronic suppurative otitis media and varies anywhere from very slight to almost total deafness.

The treatment consists of local and of surgical measures, and it is the latter we will take up. The surgical treatment consists essentially of the radical mastoid operation. Chronic aural infections may be divided into three classes: (1) Those cases of intra-tympanic infections with little or no involvement of the attic: (2) Those cases involving not only the tympanum but the attic, antrum, and—to a limited extent—the mastoid: (3) Those cases involving the intra-tympanic attic, antrum and mastoid structures as well.

The infections in class one are as a rule confined to mucous membrane, the discharge usually coming from the Eustachian tube. Hearing is good and the condition is in no way a

menace to the patient's life, hence no operation required.

In the second class of cases, we are dealing with infections that are apt to give rise to intracranial complications. Some of them are border-line cases and require quite a little study in deciding whether or not operation is to be advised.

The infections in class three are those in which the radical operation is most frequently indicated. These are the neglected cases and have existed over a long period of years. The hearing is generally very poor, the tympanum filled with foul-smelling pus and granulation tissue, the ossicles are necrosed and the mastoid shows a general involvement or is completely sclerosed. All cases of cholesteatoma, facial paralysis and intracranial complications call for immediate radical operation.

In doing the radical mastoid operation the surgical procedure is susceptible of considerable variation and several different methods are credited with excellent results. Mention will only be made of the most important steps in the operation.

The incision begins below at the tip and follows a curved direction behind the ear to a point above the upper attachment of the auricle, its center being one inch behind the post-auricular attachment. This incision divides all structures down the bone until the temporal ridge is reached, while above it only reaches the temporal fascia. The skin and periosteum are elevated in the usual way, great care being taken not to tear the periosteum which is destined to form the outer wall of the cavity proposed by the operation.

We now open the mastoid antrum by means of a gouge and mallet. We then proceed to remove the posterior bony canal wall, having already separated the membrano-cartilaginous meatus. After removal of this structure we reach what is known as the "bridge," a thin piece of bone formed by the inner margin of the postero-superior canal wall and it separates the dural plate from the facial ridge. The removal of this remaining structure presents some difficulty, certainly to the beginner, on account of the danger of injury to the bend of the facial canal and horizontal semi-circular canal which lie beneath. We now remove, by means of a small ring curette, all granulation tissue, diseased mucosa, necrosed ossicles, pus, etc., from the middle ear, care being taken not to rupture the capsular ligament which holds the stapes within the oval window. Next we lower the facial ridge to the extreme limit of safety, then clean out the epitympanic space, which requires removal of all zygomatic cells, leaving the hard, smooth, white dural plate of bone; then reduce the convexity of the anterior wall of the tympanum, then obliterate the hypotympanic space by removing the remains of the annulus tympanicus and any cells which may be found, so that there is no reservoir left in which the discharge may collect. We then curette the Eustachian tube thoroughly, removing all muco-periosteum, lowering the ridge of bone at the outer rim, being mindful that the internal carotid artery lies below and behind the tube. Finally, as a last procedure, we inspect the entire cavity to see that all surfaces of bone must be perfectly smooth and inclined to the external meatus. By removing all convex surfaces we accomplish two very important things: first, we enable ourselves to get a good view from the meatus of every part of the middle ear and Eustachian tube; second, we give the middle ear and Eustachian tube the best possible drainage.

We now pack the cavity with adrenalin gauze and proceed to cut the fibro-cartilaginous meatus. Using a blunt-pointed, narrow-bladed bistoury, we insert it into the meatus with the flat side on the floor of the meatus. We cut backward and gradually swing upward in a semi-circle with the idea of ending the incision at the base of the helix. This flap is turned backward and the newly-made meatus should admit a good-sized finger. All cartilage and *sub-mucous* tissue are dissected from the skin flap and removed. The flap is sutured with ten-day chromic gut to any part of the subcutaneous tissue or periosteum which is necessary in order to draw the flap well up.

At this stage of the operation probably a majority of otologists pack the cavity with iodoform gauze and close the primary incision. Dr. Dench, of New York, advocates in all cases using a primary Tiersch skin graft cut from the thigh, regardless of whether the dura or sinus is exposed, except those which are acutely inflamed, those in which there is a fistula in a semi-circular canal or other opening into the labyrinth, or those in which there is an unhealthy condition of dura or sinus or the presence of symptoms of labyrinthine or meningeal irritation. Having had the oppor-

tunity to assist Dr. Dench in many of his cases and to look after the post operation treatment, thus watching the results, we are convinced that the use of the primary skin graft, in a radical mastoidectomy, shortens the period of convalescence.

Our views concerning the radical mastoid operation are, in a great part, a by-product of our personal experience which consists first, of our observation of a hundred or more cases operated by other surgeons, many of which we have assisted and most of which we have treated after operation.

Second—Ten cases operated by ourselves.

From these ten radicals we are able to report the following results:

Deaths	0
Complete facial paralysis	0
Partial facial paralysis	0
Intracranial complications	0

In regard to the hearing and discharge we can only report the conditions of the patients on leaving the hospital, which was from three to four weeks following the operation. In each case the discharge was lessened and in about half of the cases the discharge was scarcely noticeable. The hearing was not impaired in any case and in several it was improved.

It is objected that the radical mastoid operation is injurious to the hearing and fails to stop the discharge. Answering these objections briefly, we will say that if the proper judgment is exercised in selecting cases for operation and every detail of technique of operation strictly adhered to and eternal patience and perseverance practiced in the post-operative treatment, these objections will be found to be more apparent than real.

Lastly, it has been objected that the radical operation is too severe and dangerous. That it is not severe is shown by the facts that the great majority of cases never have a post-operative temperature above 101 degrees and the temperature seldom lasts more than four or five days, generally a shorter period, and the patient is up in four or five days, suffering little, if any, inconvenience.

That it is not dangerous is shown by the great infrequency of post-operative intracranial complications in cases of the surgeons who have done a large number of operations, while on the contrary complications are very common with chronic purulent otitis media, and frequently more fatal than they are with infections occurring elsewhere in the body. Hence, when properly performed the radical operation is a much less frequent source of danger than the chronic infection.

Conclusions.

The published records of many operators added to our observations upon cases which we have seen and upon those which we have ourselves operated lead us to feel justified in drawing the following conclusions:

1st.—The radical mastoid operation is not indicated in all cases of chronic aural suppuration.

2nd.—That it is possible to get dry cavities in most cases.

3rd.—The hearing in the average case should be improved.

4th.—With proper technique the operation is not dangerous.

5th.—That the condition calling for operation is usually a very dangerous one and that it is too frequently dealt with lightly.

Bibliography.

Dr. J. Morrissette Smith The Laryngoscope.
Dr. Wesley C. Bowers, The Laryngoscope.
Kerrison. Diseases of the Ear.
Deaver, Surgical Anatomy of Head and Neck.

612 *MacBain Building.*

A TRUE AND TRIED TRIO.*

By ROBERT H. GARTHRIGHT, M. D., Vinton, Va.

"Man that is born of woman is of few days" * * * "He cometh forth as a flower and is cut down." "All flesh is as grass; the grass withereth and the flower thereof falleth away."

Human life is so very brief that man with his little brain has time to thoroughly learn but a few things. He who tries to obtain an accurate and comprehensive knowledge of a multiplicity of subjects, only succeeds in barely delving beneath their surface.

Hence the medical man, after getting a general knowledge of the remedies used in the treatment of diseases, should select a few of the best, study their action, and learn when and how to use them to the best advantage.

Among the drugs that have made for themselves names that will live as long as the human body shall suffer aches and pains, are,

Calomel, Castor Oil and Turpentine.

These are three good and useful remedies. The first two are workers, the last one is a healer—so taken and accepted by mothers as well as physicians. They are old and faithful

*Read at a meeting of the Roanoke Academy of Medicine.

friends of mankind, good for sick babies, grown men and women, octogenarians and centenarians.

They have cured croup, cramps, and many other complaints in the past, and, if allowed the opportunity, will do the same through the years to come. They are effectual in the treatment of the diseases of lawyers, editors, preachers, teachers, medical students, clerks and stenographers, and all persons, especially those of sedentary habits.

The first two are brain clearers. Given when needed in that capacity they will help preachers preach better, lawyers plead better, authors write better, and roentgenologists see diseased conditions of bones, etc., that actually exist.

We are informed that castor oil was known and used by the ancient Greeks and Egyptians. About the year 866 B. C. the prophet, Jonah, after his shipwreck and remarkable experience with the sentient submarine, and after having preached to the wicked Ninevehites, in a state of weariness and despondency, sought a place of solitude, and wished to die: but under a castor oil vine he found shelter from the hot rays of the sun, probably ate the fruit thereof, received energy and comfort, and went on his way rejoicing in his strength.

For centuries the product made from the bean the vine bears was neglected and apparently forgotten, but about 145 years ago Peter Canvane, a physician who practiced in the West Indies, wrote a treatise recommending its purgative principles, and its uses were restored.

Recall for how many diseases calomel is recommended by any work on the practice of medicine, and let each recall also his own experience with it. Surgeons have long recognized its capabilities and potentialities. Few patients have been operated on in Roanoke who have not been given calomel or castor oil, or both.

Let a child receive a penetrating wound of the foot, or cut its hand, the doctor, if consulted over the telephone, will tell the mother, if she has no other antiseptics convenient, to wrap it in a dressing saturated with turpentine, and the healing will usually be prompt and sure. And is not a plaster made from "pine tree rosin" and bound to the small of the back, good for lumbago?

Have those of us who prescribe the various remedies that claim to be intestinal antiseptics and often secure unsatisfactory results, forgotten the fact that our grandfathers cured their typhoid patients with oleum terebinthinae: cured a larger percent than did the boomed and boasted *acetozone* a few years ago?

Turpentine is known to be valuable in the hemorrhage of typhoid, in overcoming tympanitis in the stage of convalescence from this disease when diarrhea and relapse occur from unhealed Peyer's patches; it is good in catarrh of the respiratory system, in certain diseases of the urinary organs, as well as in various other disorders.

What is better than calomel, followed by castor oil and turpentine in cleaning the intestinal tract of the various families of worms? Verily, they are health-givers and life-savers.

Mercury has from time immemorial been used internally in vomiting and in correcting and preventing digestive disorders: externally, parasites, animal and vegetable, can be destroyed, ulcers and sores coaxed to healing, and eruptions made to disappear.

Take these three remedies, use them intelligently, and it will be found that they will cover a vaster therapeutic field, probably, than any other trio to be found in the materia medica.

The average human machine is abused by its owner, and the most common form of abuse is in surcharging it with food and drink that produce toxins. These toxins must be eliminated through the natural sewerage channels, and there are no better assistors to elimination than the ones under consideration.

Then, to aid the function of micturition, give comfort in rectal diseases, knock the kinks out of colic in babies, "move the misery" from the paunches of pickaninnies, to relieve the engorged liver, to soothe the pains caused by congestion of the mucous lining of the intestines, to heal wounds and bruises and putrifying sores, to lighten the imaginary loads of evil that press down upon the hypochondriac, calomel, castor oil and turpentine have no equals.

When analysts and practitioners and reviewers shall have by experiment and observation eliminated from the Pharmacopœia all the remedies proved to be without potency for good, among the few really valuable drugs will be these three—calomel, castor oil and turpentine.

New and numerous articles from the manufacturing houses come daily to our doors. Representatives, brilliantly verbal, tell of their

marvelous capabilities and induce us to try them. Some of them are good, and many of them prove worthless, and, if for a time we cast aside some of our old and faithful friends for others, we regret our neglect and, sooner or later, call them again to our aid.

Let us "rejoice evermore" in the results we get from the true and tried remedies, and determine to "Hold fast to that which is good."

THE WHY AND THE HOW OF ELECTRONIC (RADIANT) FORCE—PHYSICAL DIAGNOSIS — CORRELATION WITH GROSS AND MEDIUM METHODS—SOME REMARKS ON SYPHILIS

THESIS No. 5.*

By H. E. JONES, M. D., Roanoke, Va.

In order to understand the *why* and to learn the *how* of refined diagnosis and apply it, one has to be a theoretical or practical physician or both; a theoretical or practical physicist or both; a theoretical or practical chemist or both. Most of you, if not all, possess all of these requirements to a degree and what you do not possess you can acquire with a few months of diligent study.

We should all remember that there is no royal road to fortune; to perfection or near-perfection in our line of work. Both states require work, work, work; therefore we will throw aside ultra-conservatism and indifference and put ourselves in the best condition possible to render the best service (whether new or old) extant, that these modern times require.

The reason why we should learn refined diagnosis is because that it will enable us, with facility and exactness, to recognize diseases in their incipiency, which we cannot possibly do with the gross and medium methods of diagnosis alone. The latter two methods are exact, positive and certain, only in far-advanced cases of any disease. As it is our duty to secure all the evidence for single and differential diagnosis of each and every disease, at whatever stage, we are enjoined to correlate the methods and their findings, of refined, medium and gross procedures. All three of these procedures require a medicinal education and added knowledge of physics and chemistry, theoretically and experimentally, and ability for their practical application.

*Written June, 1918.

All of you are acquainted with most (if not all) of the gross and medium methods, but to a lesser degree with a part of the refined methods, and not acquainted at all with a portion or part of the latter method. This fact is the reason for the writing of this paper.

It is up to me to show the *how* of the method, which I will endeavor to do in as short a space and time as possible, by giving you later on a condensed abstract of Dr. Abrams' methods.

As to the how of refined methods, it is important for me to state that we are to deal with both gross and infinitesimal matter and radiant force and with both organized and unorganized matter and radiant forces. We are also to deal with the four states of matter and radiant force, which are the following, viz: solids, liquids, gases and radiant matter, and we are also to deal with the life of the organism and its radiant forces. The ultimate structure and properties of all of the above were treated of and described and definitions given under the head of "Physics and Chemistry" in Theses numbers 1 and 2. It is not necessary to go into them again, as we shall take it for granted that they are understood for all practical purposes by all of us.

As to the *how* of the refined method, we are to deal with the patient and in some cases with a subject, other than the patient, as well; with the disease and the effects of its radiant force on the splanchnic vessels through the splanchnic reflex vasodilator and constrictor center. When the force or forces of the disease or diseases is or are conveyed to this center, after the conditions for the examination are complied with—as to the position of the patient or subject with the axis of the earth, the arrangement for the grounding of extraneous forces, etc.—the rest is a matter of percussion and its interpretation before the disease's radiant force is conveyed to the spinal center and after it is conveyed, and a comparison of the two findings made.

We are told that the sensitivity of the brain and spinal reflex centers surpasses any instrument that has ever been invented by man. Example, the effects of light, which is a radiant force, upon the center that controls the contraction and dilatation of the pupil of the eye. The vasodilator center of the cord located between the third and fourth dorsal vertebrae is just as sensitive as the eye reflex center, and this fact is also true of all the other reflex cen-

ters of the spinal cord. All of these centers are extremely sensitive to the different types of radiant force.

Now, *it is these reflex centers and their marked sensitive response to the radiant force of diseases of which we take advantage and utilize for the purpose of refined and differential diagnosis of any disease.*

The following is Dr. Albert Abrams' method for electronic diagnosis: "(1) Face patient (or subject when used) standing, due west. Place feet on an aluminum plate grounded with conducting wire to faucet or water pipe leading to ground.

"(2) Percuss and mark lower border of liver of patient or subject. Then place receiving electrode over the source of energy, blood or diseased organ of patient, and place the other electrode between the third and fourth dorsal spines of the patient or subject. Between the third and fourth dorsal spines is the location in the cord of the reflex center of abdominal blood vessels. In 30 seconds a specific area of abdominal dullness will be elicited and persists during energy flow."

ILLUSTRATION OF DULLNESS.

"(1) Carcinoma area of dullness just below and merging into lower border of liver, left side, vertical 4 c.m: transverse 9 c.m.

"(2) Syphilis area of dullness above navel on

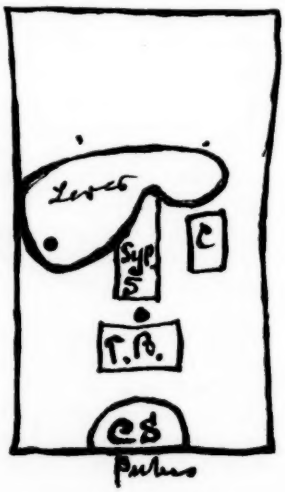

Fig. 1.

either side of median line, 6 c.m. vertical; 5 c.m. transverse.

"(3) Tuberculosis, just below navel 3 c.m. vertical and 5 c.m. transverse.

"(4) Differentiation of congenital syphilis from acquired syphilis. Place receiving electrode over either closed eye of patient and the other electrode between the third and fourth dorsal spines (splanchnic center) of subject or patient (in auto-examination). In congenital syphilis, the area peculiar to syphilis appears, but measures in its transverse diameter 10 c.m. in lieu of 5 c.m. This reaction not present in acquired syphilis in absence of ocular luetic lesion. In congenital syphilis when energy is conveyed from spine or liver of patient, there is, in addition to the epigastric area of dullness, an area measuring 10 c.m. vertically and 12 c.m. horizontally, beginning midway between the navel and symphysis pubis and extending to the latter. See figure 1."

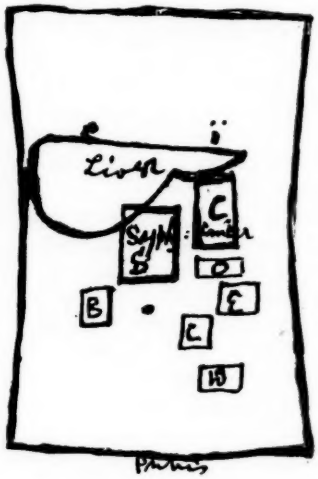

Fig. 2.

"(5) Ventral areas of dullness in syphilis when the spinal energy in this disease is conveyed to the area between the third and fourth dorsal spines: figure (2) syphilis area in all cases of syphilis irrespective of special structure invaded. In addition to the latter the area *B* is present in cardiovascular lesions; *C*, lesion of spinal cord and nerve roots: *D*, eye lesions; *E*, pulmonary lesions; *O*, also site of dullness in dementia paralytica, from energy conducted from spine of *patient* to subject (or to patient in auto-diagnosis), and this site was determined from three luetic subjects who finally developed paresis. All children of syphilitic parents are syphilitic."

"Tabes, paresis, aneurism, apoplexy before 50 years of age, is due to congenital or acquired syphilis: 50 to 55 years is due to cardio-renal disease when syphilis is not present."

"Stigma of hereditary syphilis—Argyll-Robertson pupil (nervous syphilis), tubercle of carrobelli on molar teeth—auricular and digital signs of Abrams—slow and sluggish in congenital syphilis."

"Tubercle carrobelli is a supernumerary cusp on palatine surface of upper large molars: also take notice of Hutchinsonian teeth.

"Auricular sign is a distinct ridge from antitragus to near end of lobule. Digital sign, inward curve of little finger."

Electronic Reaction With Blood.

"(1) A few drops of blood dried on slide or white paper will, when presented directly to the splanchnic center between third and fourth dorsal vertebrae of the subject, or patient, in auto-examination, yield the characteristic splanchnic area of dullness. (The radiant force from the blood will stimulate the spinal center just as light will the pupillary center.) This holds for active syphilis, tuberculosis (active or quiescent) and carcinoma. In the afflictions named the dried blood yields a reaction for about 10 days—in syphilis for several weeks. The blood reaction is a general one, indicating the disease is somewhere in the organism, localization of which is possible by methods cited above.

"In presenting the blood specimen side of paper or slide to spine, grasp it with a long pair of wood forceps or have an assistant to hold it at its extreme edge during the time percussion is executed."

"(2) Polarity (which is used for purpose of refined diagnosis). Radiant energy in disease has a distinctive polarity and is detected by presenting a bar magnet about four inches away from the area of ventral dullness. If the dullness persists with the positive pole (marked N) thus presented and disappears with the negative pole (marked S), the polarity of the radiant energy is positive and *vice versa*. If it persists with both poles, it is positive and negative, and if it is dissipated by both poles it is neutral (isopolar). Polarity of carcinoma is positive—and neutral in syphilis and tuberculosis."

"Potentiality—An ohmmeter or galvanopathometer is necessary, an instrument for demonstrating the specific radiant energy of disease." (This is necessary for refined diagnosis.)

"Note distance the receiving electrode is from the source of energy before dullness appears. An ohmmeter scale is graduated 1/25 of an ohm to one (1) ohm and then up to 50 ohms. To use the rheostat, place the receiving electrode, say, over a cancer, and the other electrode between the third and fourth dorsal spines. At zero of scale the specific dull area is present. Now interpose more resistance until dullness disappears. If dullness does not disappear until index registers 10 ohms, then energy has a potentiality of 10 ohms."

"In cancer the force varies from one to 30 ohms. In quiet syphilis reaction may not exceed 2/25 ohms: active may exceed 10 ohms. Healed tubercular lesions force 2/25 ohms: active, 20 ohms. In quiet, healed tuberculosis the reaction is present when the receiving electrode is in contact with the spine. If reaction is elicited exceeding one inch from skin, TB is active. In one case receiving electrode was seven inches from skin and the reaction appeared." In order to make as near a positive diagnosis as it is possible to make in any case: first, the history is obtained; second, patient is partially or completely stripped, as is found necessary, and is inspected from crown of head to soles of feet for the purpose of finding visible external physical defects: third, every part of body, head and limbs is searched for local infections: fourth, a conservative physical examination is made of nervous system, vascular system, respiratory, digestive, urinary and genital organs.

If by these methods and an ordinary laboratory examination, a diagnosis is made, so well and good, we proceed no further. If a satisfactory diagnosis is not made, then we bring to our aid the fluoroscope, radiographs and the refined or electron method of diagnosis. The latter findings are to be correlated with all of the above methods which will, 95 to 100 times out of a hundred, enable us to make a positive and early diagnosis in all simple, plain, apparent and obscure cases.

A word in regard to syphilis, mostly made known by electron or radiant force reactions.

"Syphilis is practically the basis of general pathology.

"The Wassermann test out of 100,000 reactions was negative in from 31 to 56 per cent of cases in which syphilis could not be positively

excluded. Syphilis may sleep, but it never dies, despite treatment or duration of the disease. The electronic reaction is never absent." "We *may* be all civilized, but we *are* all syphilized."

"When the voltage of the radio-active energy of the blood of any individual is augmented about 1300 per cent by an induction coil, the reaction of congenital syphilis is always elicited."

"In an analysis of 1,000 specimens of blood the electronic reaction of congenital syphilis showed 45 per cent in contrast with only 18 per cent of the acquired form. This is the case when the voltage was not increased by the use of the induction coil."

"No one can be a hypochondriac at pleasure; many of such sufferers yield to anti-syphilitic treatment." "Hibernation of spirochetes in the spleen permits luetic reinfection of the body." "There are three known specifics for syphilis: mercury, arsenic and iodine. The Chinese, as far back as the year 2637 B. C. (or 4,555 years ago) used mercury for syphilis and it is still pre-eminently the true specific. With mercury alone we can apparently cure syphilis—with mercury plus salvarsan we can do it better; we cannot do it with salvarsan alone. Mercury and arsenical preparations subdue acquired syphilis. Congenital syphilis is subdued by iodine or a salt of mercury containing it.

"Syphilitic infection must always be considered in all chronic diseases.

"When your diagnosis goes amiss always think of syphilis.

"Fournier says that 98 per cent of the children of syphilitic parents are syphilitic. The electronic (radiant force) reactions show that they are all syphilitic.

"Slow or sluggish pupil (reflex to light) is fairly constant in congenital syphilis, irrespective of implication of nervous system.

"Argyll-Robertson pupil is regarded as positive proof of nervous syphilis."

Auricular and digital signs of syphilis are given above.

"The vasomotorial sign—face the subject west, or patient, with feet on grounded plate, elevate the hands, a circumscribed pallor at end of fingers, notably the little finger will appear. The hands must be held between the observer and a bright light."

TEXTS—New Concepts in Diagnosis and Treatment. Journal of Physico-Clinical Medicine.—Abrams.

Published by Philopolis Press, San Francisco, Cal.

A REPORT OF TWO CASES OF PERSONAL INTEREST—A WORD IN DEFENSE OF THE TONSILS, AND PARTICULARLY AS RELATED TO SINGING-VOICE PRODUCTION.*

By M. R. FAVILLE, M. D., Roanoke, Va.

At a recent meeting of this Academy, a very interesting and instructive paper on the subject of tonsils was read by one of my contemporaries and it was right thoroughly discussed. Unfortunately I was not present and, if in this brief monograph there is a repetition of some of the points brought out at that meeting, I ask your indulgence.

In speaking of a normal faucial tonsil, one means the tonsil situated between the anterior and posterior pillars of the fauces on either side, in healthy condition, and of such size as not to project beyond the lines of the palatine arches nor press upon surrounding tissues, and of a size so small as not to interfere with the perfect outlines of the walls of the pharynx. There may be a personal idiosyncrasy in which large tonsils project beyond the palatine arches, but ordinarily a normal tonsil is hidden behind the anterior faucial pillar.

Most of us believe that a normal tonsil should not be molested and it is generally conceded among well-informed rhinologists and laryngologists that the paramount treatment for diseased tonsils is complete removal of all tonsillar tissue. In my opinion this treatment should have its restrictions and two cases in my experience have led me to this conclusion.

It is known that in childhood the tonsils are composed of lymphoid tissue, to meet the demands of the various infections to which childhood is so susceptible, and in adult life they are, as a rule, fibrous from repeated attacks of inflammation or irritation. The late Wm. L. Ballenger agreed with many other recognized authorities, such as Sir Morrell Mackenzie, Holbrook Curtis and others, that in adult life the tonsils serve no good purpose and that they should be removed when they give rise to the slightest trouble.

Diseased tonsils are a menace to the individual and as such should be removed, but occasionally a case presents itself which in my opinion should not be treated by complete re-

*Read before the Roanoke Academy of Medicine, January 20, 1919.

moval. It is true that many authorities have stated that they have seen no ill effects upon the voice by the removal of tonsils and go so far as to say that the voice invariably is improved. With the speaking voice this may be true, but I cannot find, in the literature on the subject at my disposal, where any surgeon claims that the singing voice of an adult has been improved by the removal of tonsils. The enunciation may have been improved or the nasal quality of the voice partially eliminated and the voice made larger in some instances, but in my experience the adult voice-resonance-chamber has been frequently changed by this procedure and not invariably for the better.

The voice, like musical instruments, has its sounding board. If a violin string were stretched across a heavy slab of wood or marble the tone given off would be weak and disagreeable—it would be devoid of overtones or harmonics which make it pleasing to the ear. This same string when properly adjusted on a violin gives forth a tone of sweetness and power as the sounding-board adds the overtones to the fundamental tone of the string: the fundamental tone predominates while the overtones so blend that they give color or timber. This is as true of the vocal cords as the violin string—the sounding board being composed of the head and chest: these include the pharynx, epipharynx, the nares, the accessory nasal cavities and the mouth. The soft palate acts as a valve which regulates the amount of vibrating air going to the nose and mouth. By this and the compression of the buccal walls the quality of the resonance is regulated to suit the singer's vocal expression. The anterior pillar, containing the palato-glossus and the posterior pillar embracing the palato-pharyngeus muscles act as a modulator to the voice by co-ordinating with the movements of the soft palate.

Such men as Curtis and Mackenzie say they have never seen any ill effects from tonsils having been removed, but in all probability these men did not consider the effects on the singing voice though Curtis has treated many grand opera singers. In many cases I have noticed no changes in the voice after tonsillotomy or tonsillectomy, but in two of my cases the after-effect has been too pronounced to pass unnoticed. The tonsils of adult singers who come to me for treatment are apt to receive a little more respectful consideration than those possessed by one who does not sing, and it is because of these two cases in which the singing voice was noticeably changed by the operation.

Case one was a man of 30 who possessed a beautiful tenor voice of "appealing quality" if you will allow the term: he was a salaried man who sang in church in order to augment his small income. When he came to me he had had three attacks of tonsillitis during the previous three years and insisted upon the removal of the offenders. I advised him of the possible impairment of his voice, but he was willing to take the responsibility, and I was assured that they would be removed by some one else if I refused. The tonsils showed every evidence of the attacks he had mentioned, but were no worse than many tonsils whose possessors gave no history of trouble. In removing them, especial care was taken not to injure the pillars of the fauces. The result, from an operative standpoint, was all that could be desired, and although this man retains his position in musical circles in his city there is missing that sympathetic quality or timber in his singing that was so pronounced before the operation.

Case two was a young woman of twenty years of age, who at the time of her first visit at my office, was a student in a southern college for girls. Her major subject in this school was voice culture, and she had the promise of a brilliant future. After the experience with case one I was reluctant to operate.

Her tonsils as in case one showed evidences of diseased crypts, the tonsillar tissue considerably hypertropied and hyperemic. The physician who referred her to me said he would have some one else remove them if I refused, for he felt sure that their removal would not impair her voice. The tonsils removed from this case, although they have been in alcohol five and one-half years and are not in very good state of preservation, show that they were removed intact and that in all probability the pillars to which they were attached were not mutilated, else the tonsillar surface would show the evidence. As far as one is able to judge from observation, the function of the soft palate and the muscles composing the anterior and posterior pillars was not impaired. This mutilation, according to most authorities, is the cause of impairment of some singing voices after tonsillectomy.

Dr. Ballenger states that this change in the

voice is temporary, but in the cases cited no improvement can be detected. It has been five and a half years since case two was operated and the voice, though still large and resonant and possessing many admirable qualities, has lost, and I believe forever, that rich, sympathetic quality so enviable in all singing voices. In this class of cases I would advise the patient to keep the crypts of their tonsils free as far as possible from accumulation of food, tissue debris and bacteria. This cannot always be done as occasionally the crypts are capped over by an overlying membrane, particularly in the supra-tonsillar space and the antero-inferior portion of the tonsil which is covered with the plica triangularis, but as a rule these crypts can be opened and carefully curetted. After this should be inserted an applicator saturated with a solution of glycerated tannic acid and iodine (1 dram of iodine tincture to 1 ounce of glycerated tannic acid). This not only acts as a bactericidal agent, but, in hypertrophied and hyperemic tonsils, has a tendency toward reducing them.

It is well for these patients to thoroughly inspect their tonsils every few days, and not to wait until symptoms arise before treating them. Occasionally one finds a patient who, on account of an extremely sensitive throat, cannot care for their own tonsils, but ordinarily singers' throats are under good control of the mind and they find no difficulty in treating themselves. If this treatment of keeping the crypts free from accumulation of food, bacteria, etc., does not alleviate the condition, the diseased portion should be completely removed, saving as far as possible all tissue not involved. It has been impossible to find any literature on this subject and if this brief monograph has reminded you that tonsils possessed by singers should be considered with greater respect than they ordinarily receive and thereby save the singing-voice for its possessor, and incidentally the reputation of the surgeon, I shall have accomplished my purpose.

Though many surgeons remove only tonsils that are a menace to their possessor, it is certainly true that many men (and particularly the young and enthusiastic just leaving special training) remove many harmless, innocent victims and believe in so doing they have removed the source of all ills. Most modern surgeons are in accord with an eminent New York specialist in his summary of a paper on the subject written over four years ago in which he says:

1. That the tonsils have a definite function in early childhood.

2. That tonsils should not be removed unless there is some especial indication before four years of age.

3. That small, buried tonsils associated with enlarged cervical glands should always be completely removed unless some other definite cause is found for the condition.

4. That tuberculosis is often found to be of tonsillar origin.

5. That one of the most important points to be considered in judging whether a tonsil should be removed or not, is the size of that tonsil in relation to the individual throat.

6. All tonsils, large or small, which seriously interfere with respiration should be removed.

7. That many local pathological conditions are caused by diseased tonsils.

8. That many cases of middle ear catarrh could be prevented by removal of the tonsils.

9. That there is a distinct relationship between the tonsils and many general diseases.

10. And, finally, that the promiscuous removal of the tonsils of children, without the finding of some associated pathological condition, is pernicious; and that all cases demanding operative interference should be carefully selected.

SOME GUY ROPES FOR THE DOCTOR IN PRACTICE.

By J. D. Willis, M. D., Roanoke, Va.

The blunders from omission are far greater than from commission in medical practice; consequently it is desirable to fix firmly in our minds certain procedures which are of paramount importance in the proper understanding of diseased conditions.

We must guard against jumping at conclusions, and thereby eliminate the errors in snapshot diagnoses. We should cultivate an investigative spirit in practice, and make use of aid which is available from associates in medicine by reason of their greater experience and specialization. We should secure complete data on the case under study, then analyze it with open mind, and draw our conclusions from the recognized variance from normal.

A complete history, physical examination, and necessary analytical work should be made

on all patients except those that have manifestly a local ailment or minor injury. Foci of infections must be conscientiously searched for in all cases where it is possible that such foci may be present.

The aid gotten through the specialties of internal medicine—neurology, eye, ear, nose and throat, urology, Roentgenology, and laboratory—will be found to give the greatest assistance in the proper understanding of cases. Local troubles and skin diseases should be so proven by excluding constitutional trouble with local manifestations.

A complete urine examination should be made routinely on all patients. A complete blood count should be made on all cases who are below par physically. A leukocyte count, total and differential, should be made on all cases who show a rise in temperature above normal or show a regional complaint of any kind. Catheterized urine should be examined chemically and microscopically in females suspected of acute inflammatory disease of the abdomen or pelvis. A functional kidney test should be made in all cases where it is possible that a kidney lesion may be present. Blood nitrogen chemistry should be done on all cases of suspected nephritis. A catheterized urine sediment should be stained for tubercle bacilli in all cases in which there is a tubercular process suspected or proven in the body.

All exudates and transudates should be examined by stained smear and culture. This includes specifically all pus discharges or accumulations wherever found in the body, and also all accumulations of fluid other than pus. In securing these exudates and transudates for examination it will be necessary to use the puncture needle and syringe often. With a proper knowledge of anatomy this can be done safely in a great many body locations. For instance, for diagnostic purposes, when in doubt as to whether there is a pleural accumulation or not, aspirate and, if material is found, examine it in the way previously suggested. Stool examination should be made in the warm state on all patients that are below par, or that show definite chronic disease, or show acute intestinal derangement.

A blood Wassermann test should be made on all cases that are not clearly understood. A spinal fluid study should be made on all cases showing symptoms of organic or functional nervous trouble (excepting brain tumor cases). A spinal fluid Wassermann test and cytological study should be made on all known syphilitic cases at the end of the first year after infection, or as soon as the diagnosis is made in the event the infection had taken place prior to one year before. A spinal fluid Wassermann and cytological study should be made on every case where syphilis would explain the symptoms, even though a blood Wassermann is negative. Make use of the Wassermann test to control the treatment of syphilitics according to the detailed plans advised by the United States Public Health Service. Make a careful study of *The Manual of Treatment of the Venereal Diseases* which is distributed by the United States Public Health Service. If the teachings of this manual should be carefully carried out by all civilian doctors, the greatest service to humanity which is in their hands will have been rendered.

Blood cultures should be made in septic and typhoid states. A Widal agglutination test should be made in suspected typhoid states. Blood sugar estimation should be made in all cases showing glycosuria. All tissue removed that cannot be accurately diagnosed macroscopically should be sectioned and microscopically studied. Bladder inspection by cystoscope should be done in all suspected cancer states of the genital or urinary tract. Catheterize the bladder completely in all cases of rapidly appearing abdominal or pelvic tumors.

The examination of sputum for tubercle bacilli should be made in all cases where the expectoration is continued longer than the usual time for clearing up of an acute process. Remember that very common locations for foci of infections are around the teeth, in the tonsils and sinuses, and in the prostate gland, and no examination is complete without proving that these areas are free from active infection.

TREATMENT OF BURNS.

By FAUNTLEROY FLINN, M. D., Roanoke, Va.

The following observations of burns and their treatment were made during two years' service at Dupont Hospital, City Point, Va. There was an average of one or two new cases each day.

The causes of the burns were as follows, frequency in the order named:

Acids or acid solutions;

Caustics or caustic solutions;

Hot water;

Flame—exploding gun cotton; exploding gasoline;

Hot metal;

Electric.

The area burned varied anywhere from a few scattered spots, one-quarter of an inch square to about four-fifths of body area in one case, in which patient fell into a tub of boiling acid solution. Only two-thirds of one arm, head and neck were not burned. Needless to say, he died in a few hours.

The portions of the body most frequently burned were in the following order: Hands, forearms and arms; feet, legs and thighs; face and neck; scalp; eyes (goggles were worn); trunk; buttocks and genitals.

First degree burns were comparatively infrequent and, with a few dressings, usually healed without trouble, the patient seldom stopping work. Burns of any consequence about the eyes were referred to an eye specialist.

Treatment.—As most of the burns were from acids or caustics, the first treatment was administered by a fellow-workman at the scene of accident. This consisted of a thorough washing with plain water and, in case of acid burns, an application of soda bicarbonate; then the burned area was covered with boric acid ointment.

On admission to the hospital, the parts were again thoroughly cleansed, washed with soda bicarbonate solution, and dressed with a thick layer of boric acid ointment. The dressing was changed every 24 hours until pain ceased, which was usually on the second or third day. At this time the ointment dressings were stopped and paraffin was used in the following way:

The burned area and surrounding normal skin were carefully cleansed with some mildly antiseptic solution and thoroughly dried by an electric hot air blower or by simple exposure to the air. In the meantime the paraffin had been melted in a double boiler. This was now applied to the dried surface by a soft brush or atomizer in a thin layer, extending well over the edges of the normal skin. Next a thin layer of ordinary absorbent cotton was placed and covered with a thick layer of paraffin, going well over the edges of the cotton, making the whole as nearly air-tight as possible. A gauze bandage was then applied over this dressing to hold it firmly in place. This gave a neat, comfortable, pliable and thoroughly protective dressing, which could be easily removed. By starting at one edge the whole could be lifted off with practically no pain to the patient.

In second degree burns, where the sloughings and secretions were small in amount, once in 24 hours was sufficiently often to change the dressings. Second-degree burns usually had little or no infection and healed readily in two to six months, according to the extent of area involved.

It was the third-degree burn, involving considerable area with deep sloughs and abundant secretions, that gave the trouble. They always had a foul odor and most usually became infected. The usual paraffin dressing could be used continuously until the beginning of the second or third week. At this time the secretions became copious, the sloughs began to separate, and the odor was very foul. Then it was impossible to use a continuous paraffin dressing which would prevent the escape of the secretions.

I found the following a useful procedure: About 9 o'clock each morning remove the paraffin dressing, cleanse the area of all secretions by irrigation with a mild antiseptic solution and mopping with cotton and trim away as much of the sloughing tissue as possible. Now put on a wet dressing, a pad made of cotton covered with gauze. Permanganate of potash, 1-6000 to 1-2000, is an excellent solution for wet dressings as it diminishes the odor and retards the infection. Keep the dressing warm with hot water bag. The wet dressing is used until 3 or 4 o'clock in the afternoon. The area is then exposed to the air for several hours, or at least until it is dry. Around 6 p. m. or later the paraffin dressing is applied and the patient is usually comfortable for the night.

This combination of wet dressing, open air and paraffin methods in 24 hours is troublesome, but it gives the patient the best result, with the least discomfort, in the shortest space of time.

After the burned area has become sufficiently clean, the paraffin dressing once in 24 hours is resumed.

As to the selection of the kind of paraffin to be used, this is a minor consideration. I do not believe that the many medicated and antiseptic paraffins on the market are of special benefit. The amount of antiseptic coming in contact with the infected surface is too small, also they seem to crack and break easily after applica-

tion. I found the commercial or ordinary surgical paraffin to be the toughest and most pliable.

The principal thing is to sterilize the paraffin each day, cleanse and dry the surface thoroughly and put on a sufficient quantity over enough area to give complete protection.

Although I kept no records, in comparing the amount of scar tissue formed after the use of paraffin with that after other methods of dressing burns, yet I do not believe that paraffin prevents formation of scar tissue, *except* that it is the most aseptic and protective dressing we have and we are more careful in cleansing the burned area, consequently there is no infection or only a slight amount. I do not believe it has any inherent quality that prevents scar tissue formation.

As far as I can see paraffin is the best dressing for burns that we have at our command. It is superior to other dressings in the following points:

1. Easily sterilized each day.
2. Easily applied.
3. Easily removed.
4. Most protective.
5. Clean.
6. Comfortable.
7. Inexpensive.

6 *Kirk Avenue, S. W.*

Proceedings of Societies, Etc.

HISTORY OF THE ROANOKE ACADEMY OF MEDICINE.

The Roanoke Academy of Medicine had its origin about the year 1895. The earlier records of the Society having been lost, the exact date is somewhat in doubt. Our medical organization has been known as the "Roanoke Academy of Medicine Incorporated" only about twenty odd years; a society was in existence in the town prior to that time but allowed to lapse into innocuous desuetude.

The present organization had only a few members in its first years due to the fact that the profession was unhappily torn asunder by misunderstandings and local cliques. About ten years after its formation all differences were healed, which circumstance came about in a unique way. Certain of the younger element tendered the older men a banquet at the Ponce de Leon Hotel; someone in a spirit of mischief heavily "spiked" the punch, which resulted in most of those who partook thereof reaching a state of ultra happiness. That night enemies of years "kissed and made up."

It can be truthfully stated today that the members of the Roanoke profession dwell together in harmony and have almost reached a Utopian degree in their fellowship one with another. Today the membership numbers about 71 fellows, comprising more than 80 per cent. of the regular physicians of Roanoke city and county. We regret exceedingly that a few of our prominent physicians are not recorded as affiliating with us, but hope the day is not far distant when they will join our ranks.

Largely through the efforts of the Roanoke Academy of Medicine, a competent and highly efficient Health Officer has, for the past number of years, been employed by the city. Under his supervision, a modern well-equipped laboratory is maintained, milk is rigidly inspected, food stuffs are offered for sale under sanitary conditions, vital statistics are strictly kept and the results tabulated and published from time to time, competent inspection of school children is in force, district nursing service is supervised, etc. From being at one time a town notorious for the prevalence of typhoid, the one-time so-called "Big Lick fever" Roanoke will now compare favorably with the most salubrious cities of the country in this respect; at times not a single case of typhoid has been within her borders at the height of the typhoid season.

Under the splendid regime of one member of this body, the Associated Charities of the city has co-ordinated the work of looking after the welfare of paupers and indigent sick; and the several members of the Academy are called upon in turn for a short period each for professional services. We feel our body will compare most favorably with those of like size as to quality and number of scientific essays. Our meetings are well attended and the discussions are not only interesting but of real value. We have the pleasure every year of entertaining distinguished members of the profession from far and nearby cities, and their efforts always stimulate to greater endeavors and aspirations.

As to the number of men this Society fur-

nished to the Army and Navy, articles elsewhere in this issue will set forth more exactly those who were fortunate enough to be accepted, all of whom performed their duty in a manner creditable to themselves and to their community. Those who from physical reasons or stress of circumstances could not go into actual military service, abated no effort to further the cause in every possible way and a large percentage became members of the Volunteer Medical Service Corps.

It is with sorrow we enumerate those of our number who have gone to their eternal reward, some in the fullness of years and still others in the bloom of manhood.

Among these we mention:—

Dr. Merwin Branch.
Dr. David C. Burks.
Dr. Chas. G. Cannaday.
Dr. G. W. Drake.
Dr. Richard W. Fry.
Dr. Joseph A. Gale.
Dr. I. R. Godwin.
Dr. O. W. Hacker.
Dr. J. Kinney.
Dr. J. Newton Lewis.
Dr. George S. Luck.
Dr. L. L. Schwab.
Dr. Walter S. Slicer.
Dr. F. B. Webb.
Dr. A. L. Wolfe.
Dr. Oscar Wood.

E. P. Tompkins
and
R. W. Brown.

WAR SKETCHES OF ROANOKE DOCTORS WHO HELD COMMISSIONS IN M. C., U. S. A.

We are indebted to Dr. R. L. Mason, Secretary of the Roanoke Academy of Medicine, for working up the following interesting data for our pages. This material is not alone of interest to our readers at this time but should be perpetuated in the medical annals of this State.

Ralph Waddell Brown

Born Anderson, S. C., July 9, 1867; resident Roanoke, Va., 26 years. Commissioned Captain in M. R. C., December 17, 1917; ordered to Camp Greenleaf, Fort Oglethorpe, Ga., January 22, 1918. Honorably discharged March 2, 1918, on account of physical disability existing prior to entrance into service.

W. W. S. Butler, Jr.

Lieut., (j. g.) M. C., U. S. N. R. F. Commissioned June 17, 1918, for service at Federal Rendezvous, Brooklyn, N. Y. February 18, 1919, transferred to Naval Recruiting Station at Roanoke, Va.

S. Beverly Cary

Commissioned 1st Lt., M. C., U. S. A., July 17, 1917. Reported for active duty at the Army Medical School, Washington, D. C., September 16, 1917. From there reported to the Medical Department of University of Pennsylvania for two months' instruction in reconstruction work. January 20, 1918, sailed for England to be attached to the British forces; served with them for seven months, during which time was stationed at the Welsh Metropolitan War Hospital, Cardiff, Wales, and the Special Military Surgical Hospital, London, Eng. Transferred back to the American Forces August 28, 1918, and was assigned to Base Hospital No. 8, France. Arrived U. S. A. November 20, 1918, and was assigned to duty with General Hospital No. 22, Richmond, Va. Discharged from the service March 19, 1919.

Paul Davis

Commissioned 1st Lieut., M. R. C., December 26, 1917. M. O. T. C., Camp Greenleaf, Fort Oglethorpe, Ga., February 28, 1918, to May 6, 1918. Medical assistant Base Hospital No. 54, May 10, 1918, to June 7, 1918. Left U. S. for France, August 14, 1918. Arrived U. S. from France, May 28, 1919. Received French Medal of Honor of the Service de Sante, March 18, 1919. Commissioned Captain, M. C., May 1, 1919. Discharged at Camp Dix, N. J., June 7, 1919.

T. Allen Kirk

Appointed Captain, Medical Corps, U. S. Army, September 25, 1918. Reported for active service October 10, 1918, 11th Division. Assigned to 11th Sanitary Train, Camp Meade, Md., October 10, 1918. Assigned to 242nd Field Hospital, 11th S. T., October 17, 1918. Commanding F. H. 242, December 12, 1918. Commanding 11th Sanitary Train, Camp Meade, Md., January 20, 1919. Discharged as Captain, M. C., U. S. Army, February 7, 1919.

J. Warren Knepp

Commissioned 1st Lieut., 2nd Va. Nat'l Guards, July 24, 1915. Called into Federal service with 2nd Va. Inf., June 19, 1916, for Border service. Mustered out of Federal service March 1, 1917. Called into Federal service March 25, 1917. Transferred to 115th Field Hospital, 29th Div., Oct. 1, 1917. Promoted to Captain, October 6, 1917. Arrived overseas July 12, 1918. Commanding 115th Field Hospital, December 1, 1918, to June 4, 1919. Discharged as Captain, June 24, 1919. Credit on discharge, Defense Center Sector Alsace and Muse-Argonne offensive.

George Madison Maxwell

Commissioned Captain, December 3, 1917. Ordered active duty, March 20, 1918. Chief of Sections, Eye, Ear, Nose and Throat, General Hospital No. 5, Fort Ontario, N. Y., March 20, 1918, to January 4, 1919. Discharged from service January 4, 1919. Previous military service—Corp., Co. A, 1st N. C. Volunteers, Spanish American War, April 15, 1898, to April, 1899.

William L. Powell

1st Lt., M. C. Ordered to duty in Philadelphia, January 3, 1918, for course in orthopedic surgery.

At Medical Officers' Training Camp, April 7, 1918, to May 18, 1918. At Base Hospital, Camp Sherman, Ohio, May 18, 1918, to January 7, 1919, as orthopedic surgeon. Promoted to Captain, September, 1918. Discharged as Captain, January 7, 1919.

L. G. RICHARDS

Commissioned 1st Lt., M. C., U. S. A., July 15, 1917. Ordered to School of Plastic and Oral Surgery, at University of Pa., Philadelphia, December 1, 1917. Assigned to Base Hospital, Camp Wheeler, Ga., January, 1918. January 10, made chief of Surgical Staff. May 1, 1918, assigned to Base Hospital No. 57, Chickamauga Park. July 2, 1918, received orders for overseas duty for relief Base Hospital work. For three weeks was assigned to 54th Engineers, later assigned to duty in Base Hospitals Nos. 84, 6 and 3, and finally to Embarkation Hospital No. 1, Bordeaux. Was surgeon in charge of first transport leaving Bordeaux for America, December 23, 1918. Discharged from service at Camp Dix, N. J., January 29, 1919.

W. H. SAUNDERS

Commissioned as Captain, Medical Corps, September 20, 1918. Reported for duty Medical Officers' Training Group, Camp Greenleaf, Chickamauga Park, Ga., September 30, and was assigned to Company 26-A, 7th Battalion, for military training, and to School of Military Surgery, under Lt. Col. Edward Martin. November 4, 1918, received orders to report for temporary duty, to Camp Crane, Allentown, Pa., and to obey orders to port of embarkation from the commander of Base Hospital 124. Remained at Camp Crane until December 18, 1918, time of discharge.

J. D. WILLIS

Commissioned as First Lieutenant, Medical Corps, U. S. A., October 1, 1918. Ordered to the Medical Officers' Training Group at Camp Greenleaf, Chickamauga Park, Ga., for instruction in School of Military Medicine. Discharged from service at Camp Greenleaf, December 18, 1918.

Medical officers of the Roanoke Academy of Medicine whose war sketches could not be obtained at this time:—

Dr. A. J. Black, (5 years' previous service) yet in service.
Dr. J. O. Boyd, yet in service.
Dr. F. A. Farmer.
Dr. Hicks.
Dr. G. S. Hurt.
Dr. A. P. Jones.
Dr. L. Justice, yet in Navy.
Dr. E. H. Muse.
Dr. R. G. Simmons.
Dr. W. S. Slicer (deceased).
Dr. Speed.
Dr. H. H. Trout.
Dr. Wolfe.
Dr. G. A. L. Kolmer, Salem, Va.
Dr. J. C. Darden, Salem, Va.

In addition to the above named doctors, two (2) colored doctors, of Roanoke, L. C. Downing and J. H. Roberts, held commissions in the Medical Corps.

Salem also sent one (1) colored doctor into service, W. E. Brown.

AMERICAN LARYNGOLOGICAL ASSOCIATION.

Reported by EMIL MAYER, M. D., New York, N. Y.

(*Continued from page* 43)

Cyst of the Thyroglossal Duct—A Report of Two Cases.

By OTTO T. FREER, M. D., Chicago.

The anatomic origin of these cysts is described by the author. Two cases are reported.

Case 1.—Male, began to have difficulty in swallowing, and at the same time noticed a swelling in the region of the thyrohyoid space. When first seen, on April 19, 1915, the swelling had increased and there was an increase in the difficulty in swallowing, so that to make solid food go down he had to try twice and help with a mouthful of water.

Examination showed a normal nose, pharynx, larynx and esophagus. In the thyrohyoid space a cyst was felt seemingly lying underneath the sternohyoid muscles. It was of walnut size and could be felt to interfere with the ascent of the thyroid cartilage to the hyoid bone when the patient swallowed—that is, the cyst became pinched between the two structures.

Operation on June 17, 1915. After dissecting off the superficial fascia and platysma muscle from a vertical median incision, a strong, tendinous layer of fascia was exposed that was attached to the lower border of the hyoid bone above and to the border of the thyroid notch below, so firmly binding down the cyst between itself in front, the median thyrohyoid ligament behind and the thyrohyoid membrane laterally, the cyst being unable to escape from the compartment in which it was confined when pinched during swallowing. When exposed by removing the fascia described, the wall of the semitransparent cyst was found to be so frail that it could not be seized lest it tear. This made the dissection tedious, as only the tissue surrounding the cyst could be held with tissue forceps, the cyst being held aside with dull retractors. The cyst was removed unhurt from its bed and was found to end above in a fibrous pedicle that lay against the posterior surface of the body of the hyoid bone and could be followed as high up as its superior border at the level of the hyoepiglottic ligament. Removal

of the cyst exposed the median thyrohyoid ligament to view, this ligament forming the posterior wall of the compartment in which the cyst had been confined.

Microscopic section of a part of the cyst wall showed it to be composed of fibrous tissue lined with a layer of leucocytes intermingled with numerous, evenly distributed giant cells. There was no epithelium. The cyst contained a clear fluid. The removal of the cyst enabled the patient to swallow normally.

Case 2.—The second patient was a woman of thirty-two years, first seen on November 8, 1916. She had a swelling over the larynx since her tenth year. Iodin was injected into this swelling during the summer, and since this was done the swelling had gradually increased in size.

Examination showed a spindle shaped cystic tumor of the size of a walnut in the prelaryngeal region. The upper pole of the cyst could be felt to dive under the center of the body of the hyoid bone; its lower pole dwindled to a cord that could be felt to reach the region of the thyroid isthmus.

Operation under cocain on November 17, 1916. It took two hours to dissect out the cyst, as only the most delicate handling could prevent its rupture, and inflammatory changes caused by the iodin injection had made the cyst wall grow to its surroundings, so that the thyrohyoid and sternohyoid muscles were firmly joined to it in front. The upper end of the cyst ended in a cord that extended upward under the body of the hyoid bone to its upper border, where it was lost in the hyoepiglottic ligament. Below, the cyst ended in a similar cord that joined the isthmus of the thyroid gland. When freed from its bed, just before removal the cyst ruptured, thick pus escaping, a cold abscess probably caused by the iodin injection.

After the cyst was taken away, the thyroid and cricoid cartilages, upon which it had lain, were bared to view.

In the first case the possibility of the cyst being one derived from a subhyoid bursa might come into question. However, the pedicle which formed a cord passing up under the body of the hyoid bone in the location of the thyroglossal duct, showed the thyroid origin of the cyst.

In the second case the entire thyroglossal duct, expanded to a cyst in its middle, was present to prove the correctness of the diagnosis.

The County Society.

By the request of the Council, this Department is being edited by Dr. Southgate Leigh, 109 College Place, Norfolk, Virginia, to whom all communications should be addressed.

(*Explanation*: Through a misunderstanding our "copy" for the August issue did not reach the publisher in time.)

The new *House of Delegates* will meet for the first time on Tuesday morning, October 28th. Each county socicety is entitled to one or more delegates, according to its membership.

This places the management of the State Society in the hands of the local organizations, and completes the A. M. A. plan, which was partially adopted several years ago.

Naturally the success of the plan is dependent upon the organization and development of *active* county societies.

No local society should fail to meet and elect its representatives for the initial session.

In many sections, there has been an insistent demand that the local societies should have more "say" in the management of the State organization. Now is the opportunity to accomplish their wish.

The advantages of medical organization are so plainly apparent to every thoughtful mind that there should be little need to discuss them. And yet the fact remains that the doctors of Virginia have not yet banded themselves together in such a manner as to reap these manifold advantages.

The most recent and wonderful illustration of the powerful effectiveness of organized effort has just been demonstrated in the prompt and complete mobilizing of the resources of this country, and the dealing of overwhelming and successful blows against the common enemy of civilization.

It was *organization* that accomplished this great big thing, the biggest thing that the world had ever even dreamed of.

The labor organizations of this country are so strong, that, whether right or wrong, (which point we are not considering) they usually get what they go after. This has been strong-

ly demonstrated, during the past two years especially.

Just think, *Doctors of Virginia*, the enormous amount of power for good you will have in your hands, if you will but strengthen and perfect *your organization*. And this influence which you can wield is badly needed in our State. Our medical laws are far from perfect, our institutions are in need of more help, our State Board of Health should be given greatly increased authority and much larger appropriations.

These are only a few of the good things that you can get for yourselves and for the people of Virginia, who look up to you, respect you, and put their confidence in you, more than in any other calling or profession.

Those members of our profession who are returning from their patriotic, self-sacrificing work abroad, and who *know* what organization has done, should put their "shoulder to the wheel," and help accomplish quickly this great deed for the profession and the people.

The *foundation stone* of successful medical organization is the County Unit. Why is the A. M. A. so powerful and effective for good? Because it is composed of strong and active State Society units. And the most active and productive men in the A. M. A. come from those States which themselves have the strongest organizations.

And so it must be in Virginia. Each county, or small group of counties, must have a strong, active society, comprising in its *membership all of the regular medical men* in the community, with *regular* meetings, business and scientific, and must keep in close touch with the affairs of the State Society.

This plan is not only the ideal one, but it is at the same time, the practical, common sense one, *which must and will be carried out.*

And that brings us logically to the *individual doctor*, who is really the unit on which the whole structure rests, and on whom the entire plan depends for success, *and success we must have.*

To you, then, *Mr. Individual Doctor*, we would like to address a few words. Are you an active member of a local society, and if not, why not? You have much to gain, and absolutely nothing to lose. Is it because of dislike of some other doctor? That is now out of fashion. Men can be active working members of a society, without liking each other. Is it because you are too busy? The busiest men are the ones who take the greatest interest in the local societies.

No, it is none of these. It is because you don't realize the responsibility, you don't know what good things you are missing. If you did, nothing could keep you away.

To you who are still doubtful, let us make a proposition. *Try it.* Join your local society at once, and do your part to make it successful. If you have none in your section, organize one without delay. This department will give you full information as to constitution and by-laws and charter, and will furnish you with useful printed matter.

The educational advantages of the county society are great and far reaching. This is an age of progress and development. The doctor cannot stand still. He must either go forward or backward. Improvements in medicine and surgery are being made every day, and are being published *free* to the profession. The doctor cannot keep up with the times unless he reads, attends medical meetings, and visits the clinics. There is nothing that can do more in aiding the busy doctor along these lines, than the active county society, where he can meet with his fellowmen, weekly if possible, discuss cases, read and hear papers, and listen to reports from other meetings and clinics. It is the greatest possible stimulus to study and development. And it has now become an *actual necessity.*

What sadder sight can we imagine than a doctor with wide influence, and extensive practice, seeing his patients gradually slipping away from him, simply because he is not keeping up with the times by study and development.

The editor of this department would make an earnest appeal to *each individual doctor*, to read over again this message, think about it seriously, and determine to lend his prompt, active, and enthusiastic support, to the cause.

Collection of Dues.

In other States the dues are collected by Local Societies—in this State it is optional with each society. The important point is that the State Society needs funds especially at this time, and each member should help by paying his dues *at once.*

Reading Clubs.

There is nothing more helpful for the small

society than to form itself into a journal club, each member subscribing for one or more journals, and each making a full report from time to time of all the good things in his journals. In this way the members of a small society may, at little expense, get the benefits of from ten to twenty journals. New books and pamphlets can be handled in the same way.

POST GRADUATE STUDIES.

In some sections the county societies are carrying on post graduate studies through systematic lectures and instruction. In one State the university sends its professors out on tours of instruction to members of the county societies.

Both the need and the opportunities for uplift and development are great. Organization is the *first essential.*

The President and Secretary of each organized county society which has not been doing active work, is urged to call a meeting *at once*, invite every reputable doctor to join, ask each member to pay his State dues, appoint delegates for the October meeting, and arrange an active program for the coming months.

Regular doctors in counties where no societies have been formed, are urged to get together without delay. This department will, on application, furnish all information about applying for a charter, sample copies of constitution and by-laws, and general suggestions for the organization of an active society. *The time is short—act quickly.*

The outlook for the coming year is very bright indeed. A great deal of interest and enthusiasm is being displayed. The profession of Virginia is beginning to recognize the fact that the other States are getttng ahead of us, and many of its members have made up their minds to get to work and perfect one of the strongest and most active medical organizations in this country.

All that is needed is the earnest assistance of each physician.

Will you help?

Please drop us a card and say "*YES.*"

It will encourage us and help the good work.

Look for our final message in the October issue.

Virginia Medical Monthly

ISSUED AS VIRGINIA MEDICAL SEMI-MONTHLY, APRIL, 1896 DECEMBER, 1917.

PUBLISHED BY PUBLISHING COMMITTEE, MEDICAL SOCIETY OF VIRGINIA.

ALEXANDER G. BROWN, M. D., Chairman, Richmond, Va.
A. L. GRAY, M. D., Richmond, Va.
BEVERLEY R. TUCKER, M. D., Richmond, Va.
PAULUS A. IRVING, M. D., Farmville, Va.
E. L. KENDIG, M. D., Victoria, Va.

EDITOR

A. G. Brown, Jr., M. D.

MANAGING EDITOR

Charles M. Edwards, M. D. (in Army).

All correspondence regarding editorial matters, articles, advertisements, sucscription rates, etc., should be addressed to the Journal.

All advertisements are received subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association.

Subscription Price: $2.00 per annum in advance.
Single Copies $20c.

Vol. 46. SEPTEMBER, 1919 No. 6.

Editorial.

The Roanoke Number.

We are glad to be able to devote one issue of the *Virginia Medical Monthly* to the publication of the work of Roanoke Fellows. It is the hope and purpose of this publication of the State Society to serve all its members. The difficulties of securing original articles during the past few months has been very great. We have sought aid in this matter from all sections of the State, but have been successful in only a small way. Having written letters of solicitation and besought in a personal way contributions from many, it was a peculiar pleasure for us to learn that the Roanoke Academy of Medicine had responded favorably to our invitation to furnish original contributions for one issue.

Few of our readers of the State Society know (and it is right for them to know the facts) the obstacles and difficulties through which this State journal has labored to appear each month. The story may be told at length, but the leading facts are briefly these. The Medical Society of Virginia has had no meetmg for now nearly two years and so the original articles available have been few. The widespread epidemic of influenza prevented those at home from writing, while the general exodus of physicians to army service prevented author-

ship. The advertising of the journal has been thoroughly changed so that now only advertisements conforming to the rules of the Council on Pharmacy and Chemistry of the American Medical Association are accepted. This work alone, without considering the financial risk involved in so radical a change of policy in the midst of war, and high cost of material, and labor disturbances, has been filled with unending demands of letter-writing and type and mechanical problems. The handicap of the limited office force of the journal has also been a factor in our difficulties. War conditions, with their uncertainties restricting our assistance and limiting the time in which the work of the journal could be executed, have made the publication of the journal along old lines very uncertain. This has almost completely prevented the making of certain changes in the several departments wholly out of the question.

One of the ideas which we have entertained, however, and which we have already made some effort to bring about, is the one which we this month present in the form of the ROANOKE NUMBER. This journal is by, of and for the members of the Medical Society of Virginia, and the Roanoke Fellows are speaking to you through its column this month.

The Factor of Technique in the Detection of the Influenza Bacillus.

Public Health Reports for August 29 states that one of the puzzling features in connection with the bacteriological investigations of outbreaks of epidemic influenza has been the varying frequency with which Pfeiffer's bacillus has been detected in different communities. There has been a suspicion that variations in technique may have accounted in large part for the varying results, and that this is an important element is shown by the following circumstances:

During March, 1919, an outbreak of influenza occurred in a western State. In this epidemic a very skillful bacteriologist failed to detect the influenza bacillus in appreciable numbers of cases, though he used approved methods which had given him positive results earlier in the pandemic.

In order to determine how far the chosen method was responsible for the failure to detect the organism, the Public Health Service detailed two bacteriologists, who had been able to isolate the influenza bacillus from almost every case in an outbreak that occurred in an eastern community, to attempt the detection of the organism in the locality where others had failed. These workers succeeded in cultivating the organisms from about 80 per cent of the cases of influenza studied. The cultures were made in four different blood media from swabs rubbed over the nasopharynx, while cultures made from the sputum of the same cases at the same time by the bacteriologist in charge still failed to show the influenza bacillus in a large majority of the cases.

This experience clearly indicates that the factors of individual technique and of experience in the isolation of this particular organism may make a very great difference in the results obtained with any given group of cases.

This evidence is not presented as having any particular significance with respect to the possible etiological relation of Pfeiffer's influenza bacillus to epidemic influenza, a question which is still undecided.

News of M. C. Officers.

Capt. Charles M. Edwards, Richmond, has been transferred for duty, from U. S. A. General Hospital, Ft. Riley, Kan., where he was director of the department of physiotherapy, to U. S. A. Hospital No. 43, Hampton, Va.

Dr. O. F. Blankingship, who has been in the service for the past two years, has received his discharge and returned to his home in Richmond.

Dr. John E. Cannaday, who was stationed for sometime at Base Hospital, Camp Sherman, as chief of the Surgical Staff, with the rank of major, has received his discharge and resumed his practice in Charleston, W. Va.

Major W. E. Driver has recently received his discharge from service and returned to his home in Norfolk.

Dr. Thomas M. Vorbrinck, of the 1917 class, Medical College of Virginia, who was released from the army several months ago, has located in Norfolk at 4501 Myers Avenue.

Dr. B. A. Rice, Forest Depot, has received his discharge from the service and returned home.

Dr. Ernest T. Trice, who saw service in the Fifth Naval District and aboard the U. S. ship Frederick for eighteen months, recently received his discharge from the service. Prior to resuming his work in this city early in September, he visited clinics in Philadelphia.

Dr. Robert S. Fitzgerald, of this city, who was a captain in the medical corps of the army and was stationed at General Hospital No. 2, Baltimore, Md., has received his discharge and will resume his practice in this city, with offices at 400 East Franklin Street. While in Baltimore, he attended clinics at Johns Hopkins University.

Dr. A. G. Franklin, of this city, who is stationed at the U. S. Tuberculosis Hospital at Otisville, N. Y., has been promoted to the rank of major.

Dr. Julian M. Cabell, who served abroad at the head of Base Hospital No. 41, known as the University of Virginia unit, nnown as awarded the medal of the Chevalier of the Legion of Honor which was bestowed by France. Previous to this, Gen. Pershing presented Colonel Cabell with a citation for exceptionally meritorious and conspicuous services while with Base Hospital No. 41.

Dr. H. A. Brady, the first physician of Danville, Va., to join the colors when war was declared, and who saw service in France, has returned to Danville on a visit. After a short stay there he plans making his home in Richmond.

Drs. Armentrout and Hankins.

Drs. J. F. Armentrout, Roanoke, Va., and J. L. Hankins, formerly of Fordwick, Va., have formed an association for continuing the conduct of the X-ray laboratories established by and for the past several years successfully conducted by Dr. Armentrout in MacBain Building, Roanoke, Va. Additional equipment of the most approved type has been installed and every facility employed to render accurate diagnostic data, X-ray therapy being a special feature.

Dr. Hankins has been recently discharged from the army after having served seven months of his time as roentgenologist in U. S. A. Embarkation Hospital No. 4, New York city. In this capacity, Dr. Hankins had the unusual experience of seeing a vast number of cases covering a wide range of conditions.

Dr. and Mrs. Fred A. Stoutamire,

Of Broadway, Va., have recently been visiting relatives in this city.

The Medical College of Virginia,

Richmond, commenced upon its eighty-first session on the 17th of this month. In addition to the faculty previously announced, the following new instructors have been added to the school of medicine: Drs. H. Wallace Blanton, E. C. Eggleston, T. B. Henderson, and David R. Murchison. In the list of assistants are Drs. Basil B. Jones, John Blair Fitts, C. A. Folkes, C. I. Cease, and J. L. Tabb.

"College Hall," the new dormitory for students of the College, is located at Tenth and Marshall Streets and will be able to accommodate 150 students. A cafeteria in the basement will solve the food problem for the young men who live at "College Hall."

Dr. H. A. Burke Assistant Surgeon, S. A. L.

Official announcement has been made of the appointment of Dr. H. Aulick Burke as assistant chief surgeon of the Seaboard Air Line railway, with headquarters at Petersburg, Va. He is a son of Dr. Joseph M. Burke, chief surgeon of this road.

The Richmond Meeting.

The Entertainment Committee of the Richmond Academy of Medicine and Surgery, has perfected plans for the approaching meeting of the State Society which should add much to pleasure of the members and their wives.

Tuesday, October 28th, will be the opening night and public meeting, and will include the address of welcome by the mayor of the city and the president's address.

Wednesday night, the 29th, there will be a "smoker" and vaudeville at the Westmoreland Club for the men, and the ladies will be given a theatre party or reception at the Woman's Club.

Thursday night, the 30th, there will be a reception and dance at the Jefferson Hotel.

The scientific program will include papers from such well known men as Dr. Henry A. Christian, professor of medicine at Harvard University; Col. Geo. C. Johnston, head of the X-ray department of the U. S. A., and others.

It is hoped that the members will make every possible effort to be present at this, the fiftieth anniversary meeting of the Society.

Dr. T. W. Murrell, chairman of the publicity committee, will see to it that you don't forget the date, and if you don't want your wives to accompany you, you had better not let them see his letters.

PAUL W. HOWLE, *Chairman.*

Dr. Garland H. Carter

And children, of Boydton, Va., paid a short visit to Richmond, early this month.

Lynchburg Has City Clinic for Venereal Diseases.

On July 1, the new city clinic of venereal diseases became operative in Lynchburg, Va., under the direct care of Dr. S. H. Rosenthal. All cases applying are diagnosed and treated free. By law, venereal diseases are required to be reported.

Married—

Dr. Howson Wallace Blanton, of this city, and Miss Alice Janet Wicker, Lockport, N. Y., September 2.

Dr. James Woods Price, Saranac Lake, N. Y., and Miss Sophie Mary Hoener, Montreal, Canada, September 3. Dr. Price is widely connected in this State, his home having formerly been at Ivy, Va. He was a graduate of the '01 class of the Medical Department of the University of Virginia.

Dr. A. G. Brown

And family, of this city, are home again, after a pleasant stay at Woodberry Forest, Va.

The Southside Virginia Medical Association

Held its sixty-fourth quarterly session in Franklin on September 9th, with about thirty-five doctors in attendance. An unusually good program was rendered at both the afternoon and night sessions. Officers presiding were Dr. W. T. McLemore as president *pro tem* and Dr. R. L. Raiford, secretary. At the close of the afternoon session the association was tendered a splendid supper by the Southampton County Medical Society. The meeting adjourned to meet the second Tuesday in December in Victoria.

Dr. and Mrs. William S. Gordon

Have returned to their home in this city, after spending the late summer season at Nimrod Hall, this State.

Influenza in Illinois.

The State Department of Health of Illinois reports that influenza in very mild form, without fatalities or serious complications, was unduly prevalent during the first half of July in certain localities, chiefly in the central part of the State. The cases were not generally reported, having been diagnosed as "summer cold," but investigation by State officers justifies the diagnosis of influenza. The largest group of cases was in Peoria, where it is estimated that 1,200 or more cases occurred. Only small groups of cases are reported from other localities.

The Alexandria County (Va.) Medical Association,

At a recent meeting, elected Dr. Edward McCarthy, of Cherrydale, president, and Dr. B. H. Swain, of Ballston, secretary, for the ensuing year.

Dr. W. A. Shepherd

Has returned to his home in this city after a camping trip spent with his family in the mountains of Virginia.

Mr. W. F. Rudd,

Of the Department of Chemistry of the Medical College of Virginia, was elected president of the American Conference of Pharmaceutical Faculties, at the annual meeting held in New York the latter part of August. This organization has the same relation to pharmaceutical education as has the Association of American Medical Colleges to medical education.

The American Public Health Association

Is to hold its next annual meeting in New Orleans, La., October 27-30, inclusive. Southern health problems will be the central themes of discussion and a special effort has been made to arrange the program to meet the practical needs of health officers. Winter railroad rates to New Orleans will be in effect from all points after October 1.

Department of Health for Canada.

The movement, which has been active for some years, for the establishment of a department of health in Canada, recently culminated in its introduction into the House of Commons and the final passage of a bill creating a Federal Department of Health for the Dominion. The bill provides for the establishment of a department of health, for a minister of health, a deputy minister and an advisory council. The duties and powers of the minister extend to and include all matters and questions relating to the promotion or preservation of the health of the people of Canada over which the parliament of Canada has jurisdiction.

Dr. and Mrs. Charles Blanton,

Richmond, have returned from a visit to Lockport, N. Y., where they went to attend the marriage of their son.

Miss McLeod Attends Hospital Association.

Miss Josephine McLeod, superintendent of Johnston-Willis Sanatorium, this city, was appointed by Governor Davis as a delegate from Virginia to the American Hospital Association which met in Cincinnati, this month.

Dr. J. A. Arbuckle,

Formerly of Elkins, W. Va., has located in Charleston, W. Va., where he will limit his practice to diseases of the eye, ear, nose and throat.

Dr. McG. Anders

Has moved from Gastonia, N. C., to Boone, N. C.

Dr. and Mrs. Finley Gayle,

Whose marriage recently took place in Raleigh, N. C., have returned to this city and are located at the Marion Court apartments.

Dr. and Mrs. William J. Newbill

Celebrated their golden wedding anniversary at the home in Irvington, Va., early this month.

The Association of Surgeons of the Southern Railway,

At their annual meeting in New Orleans, this summer, elected Dr. Harry T. Inge, of Mobile, Ala., president.

Lynchburg to Have Another Hospital.

The former residence of Charles Heald, of Lynchburg, Va., has been sold to Dr. Don Preston Peters, of Baltimore, Md., and it is announced that Dr. Peters will have it converted into a hospital.

Dr. Carrington Better.

We are glad to announce that Dr. Charles V. Carrington, of this city, who has been quite ill and in a hospital, is now much improved and able to be at home again.

Dr. Herbert M. Vann,

Who graduated from Jefferson Medical College in 1917 and was only recently discharged from military service after being detailed with the medical corps in France, has been elected to the chair of anatomy in the Wake Forest, N. C. School, College of Medicine. He is a son of Dr. and Mrs. L. L. Vann, of Danville, Va.

Dr. Paul W. Howle

And family have returned to their home in this city after an extended stay at Mountain Lake, Va.

Dr. William Meredith,

Of Gouldin, Va., has been appointed a member of the school board of the district in which he lives in Hanover County, Va.

Dr. and Mrs. W. B. Barham,

Newsoms, Va., went to Big Stone Gap, Va., the first of this month, where it is announced they will make their home with their daughter.

Sir William Osler Honored.

In celebration of his seventieth birthday, Sir William Osler, regius professor of medicine in the University of Oxford, England, was recently presented at the Royal Society of Medicine with two large octavo volumes of essays, contributed to by more than 150 writers—his pupils, colleagues and friends in the British empire and America. These essays cover a wide field, including medical history, education and research, as well as pathology and therapeutics.

Danville Health Department Issues Pamphlet.

The Danville, Va., Health Department is issuing quarterly a pamphlet called "Better Health" which deals with the various health problems which confront health officers. Dr. R. W. Garnett, health officer of that city, and his able corps of assistants, deserve much credit for the good work they are accomplishing in Danville.

Dr. David R. Murchison,

Who recently located in this city, has moved his offices to the Franklin Building, 301 East Franklin Street. He is limiting his practice to internal medicine.

Dr. Joseph T. McKinney,

Formerly of this city, announces his return from the American Expeditionary Forces and the opening of his X-ray laboratory in MacBain Building, Roanoke, Va.

Dr. H. Page Mauck,

Recently discharged from army service, announces the opening of his offices in the Professional Building, this city. His practise will be limited to orthopedic surgery.

Colored People of Danville to Have Hospital.

The colored people of Danville, Va., conducted a campaign last month, to raise money for the purpose of buying some property to be converted into a hospital for their race. A nice nucleus was raised for this fund.

Dr. W. H. Higgins

And family have returned to their home in this city after a visit to Virginia Beach.

Campaign to Raise Money for T. B. Sanatorium.

Danville, Va., had a campaign the first part of this month to raise $60,000 to defray the expenses of the new tuberculosis sanatorium which is to be erected on ground donated sometime ago by R. L. Dibrell, of that place. The site is several miles from the city on the Yanceyville Road, and it is proposed to build on this ground a number of bungalows.

Dr. and Mrs. A. Murat Willis

And small son have returned to their home in this city after an extended stay in the mountains of Virginia.

Dr. J. Allison Hodges,

After a visit to western North Carolina, has returned to his home in this city.

Dr. A. L. Wellford

Has returned to his home in this city after a brief visit to St. Paul and Minneapolis.

Dr. and Mrs. Henry R. Carter

And son, of Ashland, Va., have returned home after a trip to New York and Atlantic City.

Dr. and Mrs. Oscar L. Powell

Have returned to their home in Onancock, Va., after a visit to New York.

T. B. Hospital Not Menace to Health of Community.

In a suit to enjoin the city of New Orleans from establishing and maintaining a tuberculosis hospital in the city, one of the objections of the plaintiffs living in the vicinity of the proposed site was that the hospital would endanger their health. The Supreme Court of Louisiana did not take this view, stating that "a well-kept tuberculosis hospital is not a menace to the health of the people living in its vicinity; and the presumption is that this hospital will be well kept."

Dr. and Mrs. Stuart McGuire

Have returned from Canada and are at their country home on James River, just outside of this city.

Dr. G. Chambers Woodson

Has recently moved into his new home at 3208 East Broad Street, this city.

Dr. C. Mason Smith

Was re-elected city health officer of Fredericksburg, Va., at the annual meeting of the Council recently held in that city.

One Auto to Every Eighteen People in U. S.

To get an inkling of the part the automobile plays in the business and social life of a country, it is only necessary to note the number of cars in proportion to the total population of the various countries. The United States has one automobile to every eighteen persons; Great Britain, one to every 225 persons; France, one to every 400 people; Italy and Belgium, one to every 840 people.

Obituary Record.

Dr. Junius Ernest Warrinner.

The many friends of Dr. Warinner will regret to learn of his death August 29. Though a native of Charles City County, this State, in which county he was born nearly fifty-nine years ago, he had for many years made his home just outside of Richmond, and was one of the most prominent doctors in this section. After completing his education at the A. & M. College, Blacksburg, he studied medicine at the Medical College of Virginia, from which he graduated in 1884. He was prominently identified with the medical organizations of this State and was for many years a member of the Medical Examining Board of Virginia. He was modest and retiring in manner, but a loyal friend and beloved by all who knew him. His wife and several children survive him.

Dr. William Lee Dalby,

Of Bridgetown, Va., a widely-known and popular physician, died at his home August 14th after a long and tedious illness of more than two years' duration with Bright's disease. Dr. Dalby was in his fiftieth year and was a graduate of the 1891 class of the Medical College of Virginia, Richmond.

Born in Northampton County, he spent his life at his old family homestead in the active practice of his profession, loved and respected by all with whom he came in contact. His career of usefulness was not confined to the single line of medical practice. He was a broad-minded, public-spirited citizen, interested in all that pertained to the uplift and progress of his county and State. He was the last representative of a large and prominent family. His widow, Mrs. Mary Wilkins Dalby, survives him.

RESOLUTIONS ON THE DEATH OF DR. DALBY.

Whereas, in the providence of the Almighty, we are called upon to mourn the untimely death of our colleague and fellow member of The Northampton County Medical Society, Dr. William Lee Dalby, we take this occasion to express our appreciation of his high character, mental attainments and eminent qualities as a physician.

He was graduated from the Medical College of Virginia in 1891 and was a member of the county and state medical societies. He was an active worker for good roads and was secretary of the good roads commission of this county.

We have learned with profound regret of his death, and be it RESOLVED: That these resolutions be spread on the minutes of The Northampton County Medical Society, that a copy be sent to the bereaved family, and that they be published in the Eastern Shore Herald and the *Virginia Medical Monthly*.

G. FRED FLOYD,
J. M. LYNCH,
Committee.

Dr. David Mott Robertson

Died from heart disease at his home at Spout Spring, Va., August 17, at the age of 61. He was a graduate from the New York University, Medical College, in 1881. Dr. Robertson was prominent in the politics of his county, having formerly represented it in the State legislature and having been at one time treasurer of the county. He was also a member of the Medical Society of Virginia.

Dr. Charles Toomer Parrish,

A prominent physician of Portsmouth, Va., died at his home in that city, August 6, after having been in bad health for several months. He was fifty-two years of age and was graduated from the College of Physicians and Surgeons, New York City, in 1890. Dr. Parrish was identified with a number of medical associations. His wife and several children survive him.

Dr. Wilton R. Stuart,

Of White Post, Va., died July 24, at the age of 64 years. He studied medicine at the College of Physicians and Surgeons, Baltimore, from which he graduated in 1880.

Dr. Triplett Estes Lowry

Died August 14, at his home at Goodes, Va., at the age of 82 years. He had been in bad health for a number of years. Dr. Lowry graduated in medicine from the University of Pennsylvania in 1857. During the War between the States, he served first in the infantry and was later detailed to a hospital in Lynchburg, Va., in which place he served to the end of the war.

Dr. J. A. Dickey

Died at his home in Bristol, Va.-Tenn., September 4, following a stroke of paralysis, aged sixty-nine years. He was formerly mayor of Bristol, Tenn., for fourteen years. He was graduated in medicine from the National University of Arts and Sciences, St. Louis, in 1889. His wife and three children survive him.